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Keynote Address

"Partnerships Between the ACF and the IHS"

by

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Good morning. It is a pleasure to be here at your conference to speak about how partnerships help to improve the health of American Indian and Alaska Native communities and individuals by ensuring that all our people can take advantage of opportunities for education, employment, and making a positive contribution to their communities.

Improving communities is a focus of this Administration, which has been demonstrated through support of community-based programs. The IHS has promoted community building and involvement throughout our health system because research has shown that community involvement in the development of health programs helps ensure their success. The IHS focus on communities is also clearly stated in the Vision Statement of the Agency: "The vision of the Indian Health Service is one where healthy American Indian and Alaska Native communities are at the center of the circle of Indian health." That vision was first put to paper 9 years ago, but has always been a part of the philosophy and practice of IHS and Indian health programs.

I am going to begin my remarks by telling you a little about myself, the history of Indian health, and the Indian Health Service. I begin this way because whether I am speaking to a conference like this, to a group of legislators or employees at agencies in the Washington, D.C., area, or at ceremonial events – where there is a shared interest in knowing about Indian health and a healthy curiosity in what I tell others about Indian health and the agency that I lead. I believe it is important to explain the historic treaty and constitutional foundation for providing comprehensive health services for Indian people with those who are less familiar with our beginnings, and just as important to remind others of why we are here and what an honor it is to serve American Indian and Alaska Native people.

When I was a young Cherokee boy, I knew I wanted to serve Indian people. I became a dentist and began my career with the Indian Health Service 20 years ago. My path brought me to serve as the Interim Director of the Indian Health Service when President Bush appointed me in August 2002 . And in July of this year, the Senate confirmed that nomination and I became the permanent Director of the Indian Health Service. I am just as excited now, as when I joined the IHS 20 years ago, about the opportunities to serve Indian people. I had great expectations then about the possibilities for helping to improve the health of Indian people, and I was excited to work with a team of professionals. Standing before you now, my expectations haven't changed and my excitement is just as great.

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My life and my career could have taken many different paths and I am thankful that my choices brought me to where I am today, here with you, and that is where I want to be.

The history of federal health services for Indian people did not begin in 1955 with the creation of the Indian Health Service in the Department of Health, Education and Welfare. It began with choices made by our ancestors, leaders of Sovereign Indian Nations with centuries of history, to enter into treaties, the first in 1778 with the government of the newly emerging United States of America. The choices of our ancestors have resulted in the Indian health system that exists today, a system that is strongly supported by Secretary of Health and Human Services Tommy G. Thompson through his initiatives that directly benefit Indian people as well as those that benefit all Americans. The Indian health system is also supported by President Bush through his commitment to recognize and honor tribal sovereignty and tribal consultation. The programs that once were exclusively provided by the Indian Health Service have expanded and adapted to health priorities over the years, and the programs are now provided through partnerships with tribal governments and urban Indian health programs.

The history of health services for Indian people also reflects the enduring spirit of Indian people. When the Europeans arrived on this continent, there were approximately 10 million Native people. European immigrants brought small pox, plague, tuberculosis, and other infectious diseases to this continent. American Indians and Alaska Natives, who did not have immunity from foreign contagions, were particularly vulnerable to these diseases, and illness spread rapidly through Indian communities, decimating many tribal groups. By 1890 the Indian population had decreased to 250,000. During this same time period, the population of Europeans in this country went from zero to 75 million. And today the U.S. population is around 293 million, and the census estimated Indian population is around 2.6 million.

By the early 1800s, scores of Indian people living near Army posts succumbed to infectious diseases, which then threatened the health of military personnel and other Army Post workers. To curtail the spread of disease among its own, the Army physicians began providing medical treatment to nearby Indians with contagious diseases. This marked the initial provision of health care by the U.S. Government to American Indians. Improvements in the health of Indian people were made after physician services were formally established in 1849; the first nurse joined the medical staff in the 1890s; and field matrons (later Public Health Service nurses) began their health education efforts in 1891. Eventually, in 1922 the government formalized this arrangement with the passage of the Snyder Act, agreeing to provide medical treatment to federally recognized Indians and their descendants for "the relief of distress and conservation of health."

For more than 120 years, the responsibility for Indian health care was transferred among different Federal Government branches. Finally, in 1955, it settled permanently within the Department of Health and Human Services.

The spirit of Indian people has endured through the centuries and their strong voice has continued to be heard. I believe reviewing some of our history allows us to better see where we are today.

The history of the Indian Health Service shows that much has been achieved to raise the health status of Indian people since 1955. Mortality rates have decreased in almost all categories, including:

- maternal deaths,
- gastrointestinal disease,
- tuberculosis,
- infant deaths,
- unintentional injuries,
- pneumonia,
- influenza,
- homicide,
- alcoholism,
- and suicide.

And the lifespan of Alaska Natives and American Indians has increased from 51 years in 1940 to 71 years today, but that is still 6 years below the average life span of other Americans.

But health challenges still confront our people. Indian people continue to experience health disparities and death rates that are higher than the rest of the nation:

- Alcoholism - 770% higher
- Diabetes - 420% higher
- Accidents - 280% higher
- Suicide - 190% higher
- Homicide - 210% higher

Our illness and disease challenges have transitioned away from infectious disease control to challenges of chronic disease and the consequences of behavioral and lifestyle choices. That is why I believe that we must focus the efforts of the agency on establishing and strengthening health promotion and disease prevention programs rather than on the "treatment only" model, so that our people will become healthier and require fewer medical treatment services. Preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even

more important humanitarian benefit of reducing pain and suffering and prolonging life.

But the Indian Health Service, as tribal governments, urban Indian health programs, and the Administration well knows, cannot do it all alone. The President and the Secretary know that meeting the treaty responsibilities of the federal government to sovereign nations cannot be carried out by one or two agencies alone. It takes all programs of the federal government to help eliminate health disparities for Indian people – and for all Americans. And I believe that this President and this Secretary are doing their part to achieve that goal. From the outset of this Administration, they have not wavered in their commitment to improving the lives of Indian people.

One example is the bipartisan passage last week of the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003." The President's leadership, Secretary Thompson's support, and tribal advocacy ensured that the bill passed last week contained provisions that will benefit all Americans. It is particularly gratifying to note the specific references throughout the bill to the Indian Health Care Improvement Act and the numerous clarification statements referencing the IHS, Tribal, and urban Indian health programs – a reflection of the importance of equity in proposed legislative language supported by the Department. An intent of this bipartisan agreement was clearly to ensure that Indian health programs are included in future regulations, policies, and programs that will be developed from this legislation.

Items particularly important to the Indian Health Service, Tribal, and urban Indian health programs include:

- a provision that will increase reimbursement rates for rural ambulance services, which will benefit numerous isolated tribal ambulance programs throughout Indian country;
- a provision authorizing reimbursement to IHS and Tribal health facilities for emergency services provided to undocumented aliens, this is particularly important for IHS and tribal facilities in remote border locations of U.S.;
- a provision that requires Medicare participating hospitals that provide inpatient hospital services to accept Medicare-like rates as payment in full when providing services to IHS beneficiaries referred for services;
- a 5-year authorization of reimbursement for increased Medicare Part B services provided by a hospital or ambulatory care clinic operated by the IHS or Tribe;
- changes in Critical Access Hospital reimbursement rates and other provisions made available to rural hospitals, which will assist tribal and IHS operated hospitals respond to the escalating need for care by the increasing Indian elderly, youth, and infant population.

Those are some of the highlights of the bill that will benefit Indian Country. There are other provisions that will also create equity in the way rural areas – including IHS and tribal facilities – are funded under Medicare to improve reliable access to physicians, hospitals, labs, hospices and home health agencies.

An additional way to look at the bill is that it brings a degree of equity to services provided in Indian country – which certainly helps the existing programs operating in rural and reservation locations. It also provides an incentive for providers and health companies to seriously consider bringing their services further into Indian Country because the cost of doing Medicare related business has just gotten a reimbursement shot-in-the-arm. I believe there are opportunities for tribal and health businesses to explore partnerships for providing services on or near reservations.

The Medicare Modernization Act is a very good bill but, to follow the refreshing candor of Secretary Thompson, the bill does not give everyone everything they want. However, as he said at the press conference at the Press Club last week, "Medicare is such a complex program that it would be impossible to fully please everyone. But this … bill makes the most significant improvement in health care for seniors since Medicare was created on July 30, 1965."

Why am I talking about a bill that benefits elders? Because this conference is focused on building successful communities in Indian Country. One aspect of a successful community is the health status of the members of that community. Everything is tied together – the elder population is important to the continuance of traditions and culture in Indian communities. It is certainly of benefit to Indian communities to have our elders, the traditional keepers of wisdom and culture, with us and healthy throughout their lifetime. So we need to have programs of care that will sustain their quality of life with their families and within their communities for as long as possible. Projections of current levels of functional impairment and current population growth rates into the next decade suggest a 51% increase in the number of elders with functional impairment by 2010.

Just as in the rest of the country, there is a health crisis not only among our elderly population, but throughout Indian Country. The partnership of IHS, tribal health departments, and urban Indian health programs has made a significant difference in the health of our people and our communities – but our combined efforts have not eliminated health disparities. To eliminate health disparities, we must address the fact that creating healthy and successful communities is not just an access to health

issue. A successful community is one where disparities of opportunities are eliminated, such as disparities in education, in community infrastructure, in employment opportunities, in business investment, in safety, in transportation, in justice, in environmental issues, and in health status.

- As the educational and employment levels improve throughout Indian Country, so will health status.
- As the safety, security, and environmental status of Indian Country improves, so will health status.
- As the business and health infrastructure of communities and nations improves, so will health status.

The socioeconomic problems and lifestyle factors underlying the decreased health status of Indian people are entrenched, long-standing, and pervasive, and therefore difficult to eradicate. I agree with Commissioner Stamps' assessment that ACF programs can help with the social and economic development of communities, while the IHS can help with the health issues and priorities of communities.

Each action of the Administration, the Department, and the Congress – and each action of organizations like ACF, contributes to eliminating health disparities. The Administration, the Department, the IHS, and the ACF share the same goal: to further the health and welfare of American Indian and Alaska Native people. President Bush and Secretary Thompson have committed themselves to eliminating health disparities between America's population groups. Secretary Thompson particularly supports efforts to eliminate health disparities through successfully coordinating the mission, goals, and resources of all programs of the Department that specifically and indirectly benefit Indian people.

Toward that goal, Secretary Thompson revitalized the Intradepartmental Council on Native American Affairs. This council is composed of the senior leadership in the agency from each Operating Division and each program office within the Office of the Secretary. The Commissioner of the Administration for Native Americans, Quanah Crossland Stamps, serves as the chair of this Council, and I am very pleased to serve as her as vice-chair for this important Council. Under the leadership of the Secretary, the Council is seeking ways to expand tribal access to more health and social service programs of the Department in order to benefit Indian people.

For example, the Council undertook a Grants Access Study to inventory HHS programs and determine how many of those programs were being accessed by Tribes. The study indicated that HHS has 315 programs that offer grant funding. Of the 315 programs, Tribes are eligible for 125, or about 40% of grants offered by the Department. Of the 125 programs, Tribes are only accessing 85 of them. In 2004 the Council will continue this study. We will identify which Tribes are accessing which programs as well as identifying the barriers that are preventing Tribes from fully accessing the HHS programs they are eligible for. During the Regional Consultation sessions that were held last July and August, many Tribes identified barriers that ranged from the need for technical assistance to the need for better information to a host of administrative, regulatory and legislative obstacles. It is our plan not only to identify those barriers but to eliminate them.

The Council is also working closely with the Health Resources and Services Administration to identify opportunities for tribal and urban programs to benefit from the Community Health Centers program – and what changes to the criteria, within the Department's authority to change, could be considered to make the opportunity for Indian programs to participate even broader.

Helping partnerships, and tribal self-determination, along was the intent of the Secretary's action last March in sending to the Congress the HHS Title VI Self-Governance feasibility study. In that report the Secretary recommended that Self-Governance be expanded within HHS beyond the IHS to 11 other HHS programs within 3 other Agencies: the Substance Abuse and Mental Health Services Administration, the Administration on Aging, and the sponsor of this conference, the Administration for Children and Families. The report also recommended that the Secretary retain the discretion to expand the Demonstration project to six other programs. On October 1st, Senators Campbell and Inouye introduced a bill based on the HHS feasibility study, to amend the Indian Self-Determination and Education Assistance Act to provide for a demonstration program – not to exceed 5 years to allow further self-governance by Indian Tribes. The Senate Committee on Indian Affairs intends to schedule a hearing on this bill.

The combination of Indian Health Service directly provided services, tribal self-governance provided services, and tribal contracted services has been an extremely successful demonstration of the implementation of self-determination by the Tribes. Should a Tribe choose to contract to provide an ACF service for their tribal members, the IHS stands ready to assist with that process because we know, and the Tribes have demonstrated, that a self-determination partnership benefits everyone – the program, the Tribe, and most of all American Indian and Alaska Native people.

The IHS and ACF currently have some partnerships in place – partnerships that can also serve to indicate what is possible for direct ACF and tribal partnerships.

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One partnership has been in place since 1976. The intra-agency agreement between the IHS and the ACF Head Start Bureau has changed over the years as the need for services has changed. Its initial focus was on dental health, which was later expanded to health promotion support services for medical, dental, mental health, and nutrition, and most recently was modified in 1995 to include environmental health services. Our partnership has achieved a lot for the health and safety of our children by developing and implementing initiatives for diabetes and obesity prevention, and ride-safe and sleep-safe programs. The training provided on proper nutrition and healthy eating, and also services provided for mental wellness, child abuse prevention, and immunization, as well as services such as designing safe playgrounds, all help to improve our communities and expand the ability of our children to take advantage of opportunities to develop healthy lifestyles.

Another partnership is a little less historic – this one resulted in grants being awarded this past September, and continuing for three years, to tribes, tribal consortia, and urban Indian health programs for the development of reimbursement-based or otherwise sustainable long-term care services for the elderly. The Administration for Native Americans joined the IHS in this grant program and together we are funding 20 grants. The grants will go toward plans to provide personal care services for the elderly, respite care for caregivers, elder day health programs, elder housing, and reimbursable case-management services. And this is an area were there is certainly room for more partners – the IHS and ANA were only able to fund 20 out of the 60 applications received. The total amount of the 60 proposals came to $3 million. Maybe through tribal partnerships with other federal and non-federal programs the other 40 proposals can be implemented.

The IHS and ANA are also members of an interagency workgroup on improving tribal long-term care services for American Indian and Alaska Natives. The other members are the Centers for Medicare and Medicaid Services and the Administration on Aging. One of our objectives is to coordinate efforts throughout the HHS that can benefit long-term care services – an outcome of this workgroup is the grant program I just mentioned.

Since the tragedy of 9/11 the country has been developing its responses to anticipated future attacks. The IHS and the ACF, through the ANA, are collaborating to meet some of the emergency preparedness needs in Indian Country by training programs for community members and CHRs to serve as First Responders for any emergency. These efforts should enhance tribal emergency preparedness by strengthening coordination and communication among tribal, federal, state, local, and private entities.

And the IHS and ANA have another partnership – the Children and Youth Initiative. The goal of this activity is to support health promotion and wellness programs focused on reducing alcohol, tobacco, inhalant, and substance abuse by our youth; support for healthy learning environments in schools; and support for community oriented activities that promote wellness of American Indian and Alaska Native children, youth, and their families.

And the IHS and ACF have been working together since 2002, and will continue working through 2004, on the issue of domestic violence in Indian Country. Through nine tribal pilot projects and through partnerships involving the National health Resource Center on Domestic Violence, Sacred Circle, the National Resource Center to End Violence Against Native Women, and Mending the Sacred Hoop, there will be culturally appropriate prevention strategies and materials developed that will be distributed throughout Indian Country.

While the IHS looks forward to strengthening our partnerships with others and creating new ones, as the few examples demonstrate - helping strengthen Indian communities can be done through partnerships with every HHS program, with foundations and universities, and with faith based and community organizations.

Many in the audience are personally aware of the benefit of the tribally managed Community Health Representative program. The CHRs are a vital link between Indian communities and medical providers and a key component in helping with the identification of many illnesses and conditions that, if caught early, can be treated and managed and can result in far fewer serious health consequences. The IHS is collaborating with Johns Hopkins University on developing a 500-hour curriculum for training CHRs as paraprofessionals to enhance their skills to further benefit the health and well being of children, young families, and community development. When this curriculum is ready for nationwide dissemination to Indian Country, I hope that the ACF and the IHS can once again collaborate to make the distribution and training happen.

Another example of the Secretary's interest in coordinating the comprehensive resources of the Department to help meet the health needs of Indian Country is reflected in the Secretary's initiative to modernize the Public Health Service Commissioned Corps. To address the issue of expanding the number of providers serving in Indian Country, one of his modernization goals is to increase the number of Commissioned Corps health providers by 275 – and place them in Indian Health Service

and other programs that serve American Indians and Alaska Natives.

There are additional examples – but they all serve to underscore one theme; the Department wants to partner with Tribes and urban Indian health programs to eliminate health disparities among all Americans. I consider their commitment to meet the health needs of Indian people to be unprecedented. And I consider their leadership to be responsible for helping others in the Department, from senior officials to support staff, to also embrace that vision.

The Secretary has said: "We must do more with our existing programs to make them work better for Native Americans and consult with our partners to improve our policies and services to their communities." I applaud my colleague, Wade Horn, the Assistant Secretary for Children and Families, for sponsoring this important conference and opening the doors of his agency to benefit Indian communities.

President Bush has also has spoken of "bringing economic hope to every neighborhood, a good education to every child, and comfort and compassion to the afflicted." Achieving those goals will go a long way towards eliminating health disparities. Under the leadership of Commissioner Stamps, the Administration for Native Americans is taking an active role in entering the circle of partnership to help eliminate all disparities.

There are so many opportunities for making a difference and there are so many ways we can create additional opportunities. We must never be satisfied with past successes but build upon them. That, to me, is why it is so exciting working for Indian health – working with tribal and urban programs to maximize our resources, working with great leaders like Secretary Thompson and Commissioner Stamps to secure resources, and working with the employees of the Indian Health Service and the Administration for Children and Families as we do our very best to help our people.

As we face the challenges and opportunities ahead, I am confident that we can forge a better, brighter, and healthier future for American Indian and Alaska Native people.

Thank you.

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